DISPROPORTIONATE SHARE HOSPITAL
OBSTETRICIAN AVAILABILITY CERTIFICATION

HOSPITAL: _____

ADDRESS: _____

_____

_____

I hereby certify that _____, hereinafter designated the "Hospital," either (circle one):

1. **has at least two obstetricians with staff privileges at the Hospital who have agreed to provide obstetric services to Medi-Cal patients. The attachment entitled "List of Obstetricians Providing Medi-Cal Obstetrical Services," incorporated by reference herein, lists the names of these obstetricians. If, for any reason, this list should no longer be correct, the Hospital will submit a corrected list to the Department of Health Services. Failure to maintain a minimum of two obstetricians who will accept Medi-Cal patients will subject the Hospital to lose this additional reimbursement and recoupment of any funds received inappropriately; and/or**

2. **this obstetrical service availability requirement is not applicable as the Hospital predominately serves individuals under 18 years of age, or does not offer non-emergency obstetric services to the general population.**

Name: _____

Title: _____

Signature: _____

Date: _____

Telephone: _____

Attachment: **"List of Obstetricians Providing Medi-Cal Obstetrical Services"**

LIST OF OBSTETRICIANS PROVIDING MEDI-CAL OBSTETRICAL SERVICES

Date: _____

Hospital: _____

Obstetrician Name	Office Address	Telephone Number